Filing at a Glance

Company:	Pioneer Mutual Life Insurance Company
Product Name:	Application for Life Insurance
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/24/2012
SERFF Tr Num:	AULD-128694673
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	I-20833
Implementation Date Requested:	On Approval
Author(s):	Angela Riggles
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/01/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Pioneer Mutual Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Application for Life Insurance
Project Name/Number: Application for Life Insurance/I-20833

General Information

Project Name: Application for Life Insurance
Project Number: I-20833
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Angela Riggles

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/01/2012
State Status Changed: 10/01/2012
Created By: Angela Riggles
Corresponding Filing Tracking Number:

Filing Description:

This filing is for the sole purpose of revising the MIB authorization language on our Application for Life Insurance, form I-20833, which was approved in your state on July 25, 2008 (AULD-125622422).

The following sentence has been added to the Authorization and Acknowledgement section: I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB. This language appears on page 9 and has been underlined so you may easily locate it.

We certify that this is the only language change to this life insurance application.

Thank you for your assistance with this filing.

Company and Contact

Filing Contact Information

Angie Riggles, Product Analyst
One American Square
P.O. Box 7127
Indianapolis, IN 46206-7127

angela.riggles@oneamerica.com
317-285-4371 [Phone]
317-285-1297 [FAX]

Filing Company Information

Pioneer Mutual Life Insurance Company
One American Square
P.O. Box 7127
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 67911
Group Code: 619
Group Name:
FEIN Number: 45-0220640

State of Domicile: North Dakota
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50 per form x 1 form
Per Company:	No

SERFF Tracking #: *AULD-128694673* ***State Tracking #:*** ***Company Tracking #:*** *I-20833*

State: *Arkansas* ***Filing Company:*** *Pioneer Mutual Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Application for Life Insurance*
Project Name/Number: *Application for Life Insurance/I-20833*

Company	Amount	Date Processed	Transaction #
Pioneer Mutual Life Insurance Company	$50.00	09/24/2012	62990991

SERFF Tracking #:	*AULD-128694673*	***State Tracking #:***		***Company Tracking #:***	*I-20833*

State:	*Arkansas*	***Filing Company:***	*Pioneer Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*Application for Life Insurance/I-20833*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/01/2012	10/01/2012

SERFF Tracking #:	*AULD-128694673*	***State Tracking #:***		***Company Tracking #:***	*I-20833*

State:	*Arkansas*	***Filing Company:***	*Pioneer Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*Application for Life Insurance/I-20833*		

Disposition

Disposition Date: 10/01/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking #:	*AULD-128694673*	***State Tracking #:***		***Company Tracking #:***	*I-20833*

State:	*Arkansas*	***Filing Company:***	*Pioneer Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*Application for Life Insurance/I-20833*		

Form Schedule

Lead Form Number: I-20833

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		I-20833	AEF	Application for Life Insurance	Revised: Replaced Form #: I-20833 Previous Filing #: AULD-125622422	51.000	I-20833 PML 9-20-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Application for Life Insurance

(Please print in dark ink.)

American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® company
P.O. Box 2167
Fargo, ND 58107
1-800-437-4692

PART I: General Information **For general inquiries call: 1-877-999-9883**

1. Choose Company: (Hereafter referred to as "Company" – check all that apply.)

☐ ***American United Life Insurance Company® (AUL)*** ☐ ***Pioneer Mutual Life Insurance Company (PML)***

2. Proposed Insured (Please print and give full name.)

First Name *Middle Initial* *Last Name*

Street Address _____

_____ Years at This Address _____
City *State* *Zip* *County*

☐ Male ☐ Female Birthdate _____ Place of Birth _____

Daytime Phone Number _____ Evening Phone Number _____

Social Security Number _____ E-mail Address _____

U.S. Citizen? ☐ Yes ☐ No If No, give details in Question 16 and attach copy of visa.

Occupation _____ Employer _____

Employer Address _____

3. Proposed Other Insured (Please print and give full name.)

First Name *Middle Initial* *Last Name*

Street Address _____

_____ Years at This Address _____
City *State* *Zip* *County*

☐ Male ☐ Female Birthdate _____ Place of Birth _____

Daytime Phone Number _____ Evening Phone Number _____

Social Security Number _____ E-mail Address _____

U.S. Citizen? ☐ Yes ☐ No If No, give details in Question 16 and attach copy of visa.

Occupation _____ Employer _____

Employer Address _____

4. Owner and Payor – All notices and correspondence will be sent to the Owner. Complete Owner information only if different from Primary Insured.

If there are to be multiple owners, please complete the Request for Multiple Ownership form.

☐ Full Name *(first/middle/last)* _____ Relationship to Insured _____

Name of Corporation, Trust or Qualified Retirement Plan _____

Full Name of Corporate Officer, Title and State of Incorporation _____

If the Owner is a trust, please provide a copy of the trust agreement.

☐ Custodian Name _____ , Custodian Under _____ (state) ☐ UGMA ☐ UTMA

☐ Male ☐ Female ☐ Corporation ☐ Trust ☐ Qualified Retirement Plan ☐ Other _____

Birthdate or Date of Trust _____ SSN or Tax ID # _____

Street Address _____

_____
City *State* *Zip* *County*

Phone Number _____ E-mail Address _____

☐ Payor Name and Address *(if other than Owner)* _____

5. Contingent Owner

☐ Full Name _____ Relationship to Insured _____

☐ Male ☐ Female ☐ Other _____ Birthdate _____ SSN Or Tax ID# _____

Street Address _____
City *State* *Zip*

E-mail Address _____

6. Proposed Insured's Beneficiary

Unless otherwise directed, the insurance proceeds shall be divided equally among all persons who are named as primary beneficiary and who survive the insured, but if none survive, equally among all persons who are named as secondary beneficiary and who survive the insured.

Primary Beneficiary

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name of Corporate Officer and Title | *State of Incorporation*

Secondary Beneficiary (if no primary beneficiary is living)

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name of Corporate Officer and Title | *State of Incorporation*

7. Proposed Other Insured's Beneficiary

Unless otherwise directed, the insurance proceeds shall be divided equally among all persons who are named as primary beneficiary and who survive the insured, but if none survive, equally among all persons who are named as secondary beneficiary and who survive the insured.

Primary Beneficiary

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name of Corporate Officer and Title | *State of Incorporation*

Secondary Beneficiary (if no primary beneficiary is living)

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name or Name of Corporation/Trust | *Relationship to Insured* | *SSN or Tax ID #* | *DOB or Date of Trust*

Address

Full Name of Corporate Officer and Title | *State of Incorporation*

8. Premium Information

Payment Method: ☐ Single Premium $ _____
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly APP ☐ Other _____

Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? ☐ Yes ☐ No

Payor *(if other than owner)*: _____

If Automatic Premium Plan (APP) is chosen, please complete the following:

☐ Add this Premium to Existing APP for Policy # _____

☐ Start a New Draft from the Following Account: ☐ Checking ☐ Savings

Account Number*_____ Routing Number _____

Monthly Deduction Day (1st thru 28th) _____

Home Office Use Only: APP Control Number _____

***If available, attach a blank, voided check from this account for routing information.**

9. Credit Card Authorization

Initial premium payments up to $3,000 may be made by credit card. *(Not available for Variable Products)*

☐ VISA ☐ MasterCard

Cardholder's Name _____

Card Number _____ Expiration Date *(mm/dd/yyyy)* _____

I authorize a premium deposit to be made by charging the credit card listed above in the amount of: $_____ in connection with this application for life insurance. I acknowledge that use of the credit card for payment is optional and that this authorization does not cover the charging of future premiums. I have received and have read the Temporary Insurance Agreement. It has been explained to me by the agent and I understand and agree to all the conditions and limitations.

Cardholder's Signature _____

10. Nonforfeiture Information

☐ Automatic Premium Loan (if available) ☐ Yes ☐ No (If not completed, APL will be applied if applicable, except in Illinois.)

☐ Qualified Retirement Plan

If Qualified Retirement Plan is selected, the automatic nonforfeiture option is paid-up insurance.

11. Insurance on Proposed Insured

Variable Universal Life (complete Investment Option Election form (IOE))

THE AMOUNT AND DURATION OF THE DEATH BENEFIT MAY VARY BASED ON THE INVESTMENT PERFORMANCE OF THE SEPARATE ACCOUNTS' INVESTMENT RETURN. THE CASH VALUE MAY INCREASE OR DECREASE BASED ON THE INVESTMENT PERFORMANCE OF THE SEPARATE ACCOUNTS' INVESTMENT RETURN.

Flexible Premium VUL

Life Insurance Qualification Test ☐ Guideline Premium Test ☐ Cash Value Accumulation Test (CVAT)

Note: If qualification test is not marked, Guideline Premium Test will be automatically chosen.

Base Face Amount: _____ Supplemental Face Amount: _____

Death Benefit Option ☐ Option 1(A) ☐ Option 2(B) ☐ Option 3(C)

Initial Premium $ _____ Planned Premium $ _____ How much is §1035 money? _____

Riders *(may not be available in all states)*:

☐ CBR *(Children's Benefit Rider)*
_____ units *(1 unit min.; 20 units max.)*

☐ CPD *(Credit of Premiums for Disability)*
Monthly Amount $ _____

☐ GIO *(Guaranteed Insurability Option)*
$ _____ *($10,000 min.; $100,000 max.)*

☐ Extended No-Lapse Guarantee

☐ Other Insured Term $ _____

☐ Premium Deposit Account $ _____

☐ WMDD *(Waiver of Monthly Deductions for Disability)*
(WMDD is required for CPD)

☐ Other _____

11. Insurance on Proposed Insured *(continued)*

Whole Life Insurance

Basic Policy Plan: ☐ **Liberty Select** ☐ **Legacy** **Limited Pay Period:** _____ **years** ☐ **Legacy 121**

Face Amount of Basic Policy $ _____

Riders *(may not be available in all states)*:

☐ Accelerator Paid-up Additions Rider
Billed Premium* $ _____
Rider Premium Duration _____ *(years paid)*
How much is §1035 money? $ _____
Non-§1035 single premium? $ _____

☐ Blend Accelerator Paid-up Additions Rider
Billed Premium* $ _____
How much is §1035 money? $ _____
Non-§1035 single premium? $ _____

☐ BIR *(Blended Insurance Rider)*
Face Amount $ _____

☐ CBR *(Children's Benefit Rider)*
_____ units *(1 unit min.; 20 units max.)*

☐ CPUAD *(Credit of Paid-up Additions for Disability Rider)*
(must match WPD)
Monthly Benefit Amount $ _____
☐ 2 year own occupation
☐ 5 year own occupation

☐ GIO *(Guaranteed Insurability Option)*
$ _____ *($20,000 min.; $100,000 max.)*

☐ SPO *(Survivor Purchase Option)*
Face Amount $ _____
($100,000 min.; 10x base policy max.)
Must complete Proposed Other Insured information.
Insured Beneficiary Name: _____

☐ WPD *(Waiver of Premium for Disability)*
☐ 2 year own occupation
☐ 5 year own occupation

☐ Other _____

**Billed premium same mode as policy*

Available on Legacy Only:

☐ Same Insured Term $ _____
Guaranteed Period _____
☐ Waiver Conversion Option
(WPD must be chosen)

☐ Other Insured Term $ _____
Guaranteed Period _____

Available on Legacy 121 Only:

☐ EBIR *(Enhanced Blended Insurance Rider)*
Face Amount $ _____
Annual Premium $ _____

Universal Life Insurance *(Underwritten by Pioneer Mutual Life Insurance Company)*

Life Insurance Qualification Test ☐ Guideline Premium Test ☐ Cash Value Accumulation Test (CVAT)
Note: If qualification test is not marked, Guideline Premium Test will be automatically chosen.
Base Face Amount: _____ Supplemental Face Amount: _____
Death Benefit Option ☐ Option 1(A) ☐ Option 2(B) ☐ Option 3(C)
Initial Premium $ _____ Planned Premium $ _____ How much is §1035 money? _____

Riders *(may not be available in all states)*:

☐ CBR *(Children's Benefit Rider)*
_____ units *(1 unit min.; 20 units max.)*

☐ CPD *(Credit of Premiums for Disability)*
(must match WMDD)
Monthly Amount $ _____
☐ 2 year own occupation
☐ 5 year own occupation

☐ GIO *(Guaranteed Insurability Option)*
$ _____ *($10,000 min.; $100,000 max.)*

☐ Other Insured Term $ _____

☐ WMDD *(Waiver of Monthly Deductions for Disability)*
(WMDD is required for CPD)
☐ 2 year own occupation
☐ 5 year own occupation

☐ Other _____

Term Insurance

Basic Policy Plan: _____ Face Amount $ _____ Guarantee Period _____

Riders *(may not be available in all states)*:

☐ CBR *(Children's Benefit Rider)*
_____ units *(1 unit min.; 20 units max.)*

☐ WPD *(Waiver of Premium for Disability)*
☐ 2 year own occupation
☐ 5 year own occupation
☐ Waiver Conversion Option

☐ Other _____

12. Dependent Children Proposed for Child Benefit Rider

a. *Print Full Name* *Relationship* *Birthdate* *Height* *Weight*

b. Are all children listed? ☐ Yes ☐ No (Explain Why Not) _____

13. Dividend Option (Whole Life only)

☐ Cash (Opt. 1)
☐ Accumulate at Interest (Opt. 2)
☐ Reduce Premium (Opt. 3)
☐ Paid-Up Additions (Opt. 4)
☐ Offset Premiums by Surrendering Paid-up Additions *(if sufficient)*
Beginning Policy Year _____
☐ Other _____

14. Annual Income of Proposed Insured

Earned $_____ Unearned $_____ Net Worth $_____

In the past seven (7) years, have you filed for bankruptcy? ☐ Yes ☐ No

Bankruptcy Type: ☐ Personal ☐ Business ☐ Other Date Discharged? _____

15. Information Regarding other Coverage (Applies to all proposed insureds)

a. Do you have existing life insurance or annuity(ies) with this or any other company? ☐ Yes ☐ No

b. Will this policy be replacing or changing any existing life insurance or annuity with this or any other company?
☐ Yes ☐ No If yes, provide details below.

c. List all life insurance or annuities in force on Proposed Insured(s):

				Replacement?		§1035
Amount	Issue Year	Type	Company / Policy No.	No	Yes	Exchange?

d. Is an application for life, health insurance or annuity pending with this or any other company? ☐ Yes ☐ No
If Yes, Company Name _____ Amount $ _____

e. Have you ever sold a policy to a life settlement, viatical or other secondary market product provider, are you in the process of selling a policy, or planning a future sale? ☐ Yes ☐ No
If Yes, Company Name _____ Amount $ _____

f. If the proposed insured is a juvenile, what is the total amount of life insurance in force on the parent(s)? $_____
If not insured, why not? _____

Complete the following for all siblings:

Age	*Amount In Force*	*Age*	*Amount In Force*

16. Special Requests/Additional Information

_____

_____

_____

_____

_____

_____

PART 2: Underwriting Information

17. Health Questions (Complete for all proposed insureds; optional for those being examined.)

Primary Insured: Height _____ ft. _____ in. Weight _____ lbs. ☐ Gained ☐ Lost _____ lbs. In past year
Second Insured: Height _____ ft. _____ in. Weight _____ lbs. ☐ Gained ☐ Lost _____ lbs. In past year

PART 2: Underwriting Information (continued)

17. Health Questions (Complete for all proposed insureds; optional for those being examined.)

A. During the past ten (10) years has any person proposed for insurance been diagnosed as having, or been treated for:

	Primary Insured	Second/Other Insured
1. Heart attack, high blood pressure, stroke, or other disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No
2. Cancer, tumor, lymph gland or thyroid disorder, chronic fatigue, leukemia, or any other blood abnormalities?	☐ Yes ☐ No	☐ Yes ☐ No
3. Diabetes or other endocrine disorder; disorder of the kidney, bladder or prostate?	☐ Yes ☐ No	☐ Yes ☐ No
4. Lung or chronic respiratory disorder, asthma, bronchitis, emphysema, pneumonia, tuberculosis, or any other disorder of the respiratory system?	☐ Yes ☐ No	☐ Yes ☐ No
5. Intestinal bleeding, ulcer, hepatitis, or other disorder of stomach, liver, intestine, gall bladder or pancreas?	☐ Yes ☐ No	☐ Yes ☐ No
6. Any disease or disorder of the reproductive organs or breasts?	☐ Yes ☐ No	☐ Yes ☐ No
7. Brain, mental or nervous disorder, fainting, convulsions; paralysis, depression, anxiety, frequently recurring headaches or any other disease or disorder of the nervous system, attempted suicide or ever been counseled for any of the above?	☐ Yes ☐ No	☐ Yes ☐ No
8. Arthritis, loss of limb or deformity, disorder of bone, joint, muscle, back, spine or neck, skin disorder or any other disorder of the skeletal system?	☐ Yes ☐ No	☐ Yes ☐ No
9. Disease or disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
10. Immune Deficiency – Has the proposed insured:		
a. ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia?	☐ Yes ☐ No	☐ Yes ☐ No
b. diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No

B. During the past five (5) years has any person proposed for insurance:

1. Been advised to take or is now taking treatment or medication or under prescribed diet?	☐ Yes ☐ No	☐ Yes ☐ No
2. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No
3. Had any diagnostic test, such as an EKG, treadmill, heart cath, X-ray, MRI, CT scan, biopsy or blood study?	☐ Yes ☐ No	☐ Yes ☐ No
4. Has been an inpatient or outpatient in a hospital, clinic or medical facility or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No
5. Been advised to have any diagnostic test, hospitalization or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No

C. Has or is any person proposed for insurance:

1. Pregnant? If Yes, list the anticipated delivery date. _____	☐ Yes ☐ No	☐ Yes ☐ No
2. During the last five years, made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition and/or been unable to work, attend school or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No	☐ Yes ☐ No
3. During the last five years, had any illness, disease, or injury not mentioned in A or B above?	☐ Yes ☐ No	☐ Yes ☐ No

Details of all "Yes" answers. (Identify Primary or Second/Other Insured, question number, circle applicable items; include diagnosis, treatment, dates of diagnosis, dates of treatment, duration and names and addresses of all attending physicians and medical facilities.)

18. Personal Information (Complete for all proposed insureds and identify to whom any "Yes" answers apply.)

Provide details to any "Yes" answers below.

	Primary Insured	Second/Other Insured
a. Driver's license number(s) and state(s) of Issue: Primary Insured: _____ Second/Other Insured: _____		
b. Have you been convicted of a driving violation, driving under the influence of alcohol or drugs, or had your license suspended or revoked?	☐ Yes ☐ No	☐ Yes ☐ No
c. Plead guilty to or been convicted of a felony or misdemeanor or do you have such charge currently pending against you? *If Yes list the nature of the plea, conviction or charge, the date and State where the plea, conviction or charges occurred, whether time was served in prison and status of probation.*	☐ Yes ☐ No	☐ Yes ☐ No
d. Has any company declined, postponed, rated or refused to reinstate insurance?	☐ Yes ☐ No	☐ Yes ☐ No
e. Has the proposed insured ever:		
1. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
2. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No
3. Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous?	☐ Yes ☐ No	☐ Yes ☐ No
f. Have you participated in any vehicle racing, parachuting, hang gliding, scuba diving, ballooning, rock or mountain climbing or spelunking within the past two (2) years or is any such activity contemplated? *If Yes, complete the Avocation Supplement.*	☐ Yes ☐ No	☐ Yes ☐ No
g. Have you flown within the past two (2) years as a pilot, student pilot, crew member or had any flying duties, or is any such activity contemplated? *If Yes, complete the Aviation Supplement.*	☐ Yes ☐ No	☐ Yes ☐ No
h. Do you contemplate travel or residence in a foreign country within the next 24 months? *If Yes, complete the Foreign Travel Supplement.*	☐ Yes ☐ No	☐ Yes ☐ No
i. Do you have any current or expected connection with the Armed Forces? *If Yes, complete the Armed Forces Supplement.*	☐ Yes ☐ No	☐ Yes ☐ No
j. Has the proposed insured ever used any nicotine *(including substitutes such as gum, patch, etc.)* and/or tobacco products? *If Yes, provide detail below.*	☐ Yes ☐ No	☐ Yes ☐ No
1. ☐ Present ☐ Former		
2. Type of nicotine or tobacco used: _____		
3. When did you quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year		

Details of all "Yes" answers.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name(s) and address(es) of personal physicians (if none, so state)

Primary Insured _____ Second Insured _____

_____ _____

Date and reason last consulted _____ Date and reason last consulted _____

_____ _____

List any medications taken daily _____ List any medications taken daily _____

_____ _____

19. Proposed Insured Family History

Cancer (all types)	*Heart Disease, Stroke or Other Circulatory Disorder*	*Diabetes*		*Age If Still Living*	*Age At Death*	*State of Health/Cause of Death*
				Provide details for Yes answers.		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Mother			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Father			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Siblings			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				

20. Proposed Second/Other Insured Family History (Not required for children covered under CBR)

Cancer (all types)	*Heart Disease, Stroke or Other Circulatory Disorder*	*Diabetes*		*Age If Still Living*	*Age At Death*	*State of Health/Cause of Death*
				Provide details for Yes answers.		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Mother			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Father			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Siblings			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				

Agreements

I (we) represent that I (we) have read and understand all the statements and answers given in this application and that they are true and complete to the best of my (our) knowledge and belief. It is agreed that:

a. the statements and answers given to this application and any amendments to it or made to the medical examiner will be the basis of any insurance issued;
b. no representative or medical examiner has the authority to make or alter any contract for the company;
c. the company may indicate changes in an endorsement to this application for administrative purposes only, and I must agree in writing to any other changes in this application;
d. if an initial premium has been made, and a Temporary Insurance Agreement (TIA) bearing the same name and date as this application has been received, no insurance will be effective before policy delivery except as provided in the TIA.
e. if no initial premium payment has been made at the time of making this application, or if the company approves this application different from that applied for as to plan, amount, age, classification or benefits, no insurance will take effect until (a) the policy is delivered to and accepted by me and (b) the full first premium is paid and (c) to the best of the applicant's knowledge, the health and insurability of any person proposed for insurance has not changed since the date of this application.

I (we) and the representative certify that I (we) have read, or had read to me (us), the completed application and I (we) realize that any false statement or misrepresentation therein may result in loss of coverage under the policy.

Acknowledgement

This section must be completed by the proposed policy owner regardless of whether the TIA is given.

PLEASE MARK THE ONE BOX THAT APPLIES, UNMARKED BOXES ARE NOT APPLICABLE

☐ I have NOT made a premium deposit with this application nor have I received the Temporary Insurance Agreement.

☐ I have made a premium deposit in the amount of $_____ in connection with the application for life insurance. I have received and have read the Temporary Insurance Agreement (TIA). It has been explained to me and I understand and agree to all of the conditions and limitations.

PLEASE ALSO MARK THE FOLLOWING BOX, IF APPLICABLE (does not apply to Variable Products)

☐ I acknowledge that an illustration conforming to the policy applied for was ***not*** provided. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Interview Information

Home Phone: _____ Best Time to Call _____ a.m. _____ p.m.

Business Phone: _____ Best Time to Call _____ a.m. _____ p.m.

May we interview the spouse or an adult member of the family? ☐ Yes ☐ No

Fraud Warning

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Authorization and Acknowledgement

I (we) authorize any physician, medical practitioner, hospital, medical facility, insurance company, DMV and the MIB to give all the companies who are listed as a OneAmerica® company and its reinsurers any of the following about me (us) or my (our) children, if they are to be insured: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. All sources except the MIB may give these facts to any insurance support organization authorized by a OneAmerica company to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. I authorize any company listed as a OneAmerica® company and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. I can choose to be interviewed if an investigative consumer report is made. Upon request, I (we) can receive a copy of the investigative consumer report. I (we) have received the Notice of OneAmerica's Information Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice, and the Authorization and Acknowledgement. I (we) or my (our) authorized representative can receive a copy of this authorization form.

Substitute W-9 Certification

I (we) certify, under penalty of perjury that 1) the number(s) shown on this form is my (our) correct taxpayer identification number(s), or I (we) am (are) waiting for a number to be issued to me (us); and 2) I (we) am (are) not subject to backup withholding because: a) I (we) am/are exempt from backup withholding or b) I (we) have not been notified by the Internal Revenue Service that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me (us) that I (we) am/are no longer subject to backup withholding; and (3) I (we) am (are) a U.S. citizen or other U.S. person (as defined in Form W-9 located at www.irs.gov).

☐ **Check this box if you have been notified by the IRS that you are currently subject to withholding because of under reporting interest or dividends on your tax return.**

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

Signatures

Signed at: _____ on _____ (mm/dd/yyyy)
City, State *Date*

Proposed Insured	_____	_____
Proposed Second/Other Insured	_____	_____
Proposed Other Insured #2	_____	_____
Proposed Other Insured #3	_____	_____
Payor, owner or applicant other than Proposed Insured	_____ *Printed Name*	_____ *Signature*

Any child over age 15 proposed for insurance must sign. If proposed insured is under age 18, parent must also sign.

FOR VARIABLE PRODUCTS, PLEASE ACKNOWLEDGE:

I hereby acknowledge receipt of the current prospectus, and any supplements for this policy including any required disclosure if the policy applied for will be in a qualified plan.

Please check, if applicable:

☐ Yes, I have a CD-ROM drive on my computer and am able to view all of the prospectuses.

For a printed version of the prospectuses, please call **1-800-537-6442**. *Variable contracts issued by AUL are distributed by OneAmerica Securities, Inc., Member FINRA, SIPC, a wholly-owned subsidiary of AUL.*

_____ _____
Signature *Date*

Please make all checks payable to (Check appropriate box):

☐ American United Life Insurance Company® *(Standard Risk Term, Whole Life, Variable Life)*

☐ Pioneer Mutual Life Insurance Company *(Standard Risk Universal Life)*

Representative's Statement

Do you have any knowledge or reason to believe that replacement of existing insurance or annuity coverage may be involved? ☐ Yes ☐ No

(If "Yes," give details in Section 15 and complete any state required replacement forms.)

Did you witness the signatures on this application? ☐ Yes ☐ No

How did you identify the proposed insured? ☐ Well known to you ☐ Photo ID ☐ Related

(If related, or well-known to you, please explain) _____

List any former names of the proposed insured(s) _____

Should this application be evaluated with any other applications? ☐ Yes ☐ No

If "Yes," please provide: Name: _____ *Relationship to Insured:* _____

☐ I certify that an illustration was ***not*** used in the sale of this policy.

☐ I certify that the policy is applied for other than as illustrated.

I certify that (1) the information provided by the owner and proposed insured(s) has been accurately recorded and (2) I have reasonable grounds to recommend the purchase of the policy as suitable for the owner and the proposed insured(s).

I submit this application assuming full responsibility for delivery of any policy and for immediate transmittal to the Company of the first premium when collected. I know of no condition affecting the insurability of any person proposed for insurance not fully set forth herein. I certify that a written disclosure statement, where required by law, was given to the applicant when this application was taken.

_____ _____

Name of Representative (Please Print) *Representative's Signature*

_____ % *Representative's AUL Code* _____ *Representative's PML Code* _____

_____ _____

Name of Representative (Please Print) *Representative's Signature*

_____ % *Representative's AUL Code* _____ *Representative's PML Code* _____

_____ _____

Name of Representative (Please Print) *Representative's Signature*

_____ % *Representative's AUL Code* _____ *Representative's PML Code* _____

Agency or Broker/Dealer: _____

If the Company has questions concerning this application, whom should we call at your office?

Name _____ Phone Number _____ Fax Number _____

E-mail Address: _____

Principal Review (Required for registered products only)

_____ On _____

Field Office Principal *Date*

Accepted by American United Life Insurance Company® at the Home Office by:

_____ On _____

Home Office Principal *Date*

Send Application To:

If you have any questions completing this application or any other supporting documentation, please call 1-877-999-9883.

Please mail this application to the following address:

U.S. Postal Delivery:
OneAmerica Financial Partners, Inc.
Attn: Individual New Business
P.O. Box 6003
Indianapolis, IN 46206-6003

Overnight Delivery:
OneAmerica Financial Partners, Inc.
Attn: Individual New Business
250 W. North Street
Indianapolis, IN 46202

FOR MOST EXPEDIENT DELIVERY – SUBMIT ALL APPLICATIONS IN THE YELLOW NEW BUSINESS ENVELOPE #7-13507.

TEMPORARY INSURANCE AGREEMENT

PLEASE NOTE: THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF INSURANCE (THE LESSER OF $300,000 OR THE AMOUNT OF INSURANCE APPLIED FOR UNDER THE APPLICATION FOR INSURANCE HAVING THE SAME DATE AS THIS AGREEMENT), IF ALL THE CONDITIONS SET FORTH HEREIN ARE FULLY SATISFIED. THE COVERAGE PROVIDED IN THIS AGREEMENT IS IN EXCHANGE FOR THE DEPOSIT RECEIVED TOWARD THE INSURANCE APPLIED FOR AND NO AMOUNT SHALL BE CHARGED FOR THE COVERAGE PROVIDED HEREIN. NO REPRESENTATIVE OR AGENT HAS THE AUTHORITY TO WAIVE OR CHANGE THE TERMS OR CONDITIONS OF THIS AGREEMENT.

HEALTH QUESTIONS

1. Within the past 90 days, has any person proposed for insurance been a patient in a hospital or other medical facility, had surgery or been advised to be hospitalized or have surgery? ☐ Yes ☐ No
2. Within the past 2 years, has any person proposed for insurance been treated for heart trouble, stroke, diabetes, cancer or been advised by a medical professional to have such treatment? ☐ Yes ☐ No
3. Has any person proposed for insurance been diagnosed or treated for AIDS by a member of the medical profession, or had a positive test result confirming the presence of the AIDS virus (e.g. HIV, HTLV-III)? ☐ Yes ☐ No

If any Health Question is answered "Yes", give question(s) and name of applicant.

_____

_____

No insurance is provided under this Agreement on any applicant(s), answering "Yes" to a question above. If any Health Question is not answered, this agreement is void.

NOTE TO REPRESENTATIVE: If any question is answered "Yes", do not accept cash or detach this agreement.

DEPOSIT

Received from _____ the sum of _____ as a deposit in connection with an application for insurance having the same date as this Agreement. The deposit shall be held and applied toward the first premium owed from the effective date of any policy issued and accepted as part of said application.

There shall be no coverage under the insurance applied for until a policy is issued and accepted. If no policy is issued and/or accepted, the deposit shall be refunded to you.

CONDITIONS

Insurance on applicant, up to the Amount Limitation, will begin on the effective date, if:

1. There is no material misrepresentation in the application or answers to the Health Questions, and
2. All of the Health Questions are answered "No" with respect to that applicant; and
3. The deposit received is equal to the premium for the mode selected in the related insurance application.

If the deposit is paid by check that is postdated or is not honored on presentation, the Agreement is void.

If a person proposed for insurance dies by suicide, while sane or insane, the death benefit will be only the amount of the deposit paid.

EFFECTIVE DATE

"Effective Date" means the latest of:

1. The date of the application.
2. The date of the last medical exam initially required under the Company's underwriting rules. Any required medical exam must be completed within 30 days after the date of this Agreement, if not, this Agreement will be void with respect for that person proposed for insurance.

AMOUNT LIMITATION

The total amount of insurance which may take effect on any person proposed for insurance under this and all Temporary Insurance Agreements is $300,000 of life insurance (including accidental death).

TERMINATION OF TEMPORARY INSURANCE

Insurance under this Agreement will terminate with respect to all of the persons proposed for insurance on the earliest of:

1. The date that insurance begins under the policy applied for or under a policy issued other than as applied for.
2. Ten (10) days after a policy other than as applied for is offered to the Proposed Insured or Owner.
3. Five (5) days after the Company mails a letter of declination to the Proposed Insured or Owner.
4. Sixty (60) days after the date of the application.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE REPRESENTATIVE OR LEAVE THE PAYEE BLANK.

I have read this Agreement and understand and agree to its terms. I understand this receipt provides no insurance unless all of its conditions are met and all required medical exams are completed. I declare that the answers to the Health Questions are true and complete to the best of my knowledge.

_____ _____

Date *Proposed Insured Signature*

By _____ _____

Representative *Owner (If other than Proposed Insured)*

IF YOU HAVE NOT RECEIVED YOUR POLICY WITHIN 60 DAYS OF THE DATE OF THIS CONTACT THE COMPANY AT P.O. BOX 6003, INDIANAPOLIS, IN 46206. ATTN. UNDERWRITING DEPT.

Representative's Note: Send original to Home Office with application and give copy to Proposed Insured (owner, if other than Proposed Insured).

TEMPORARY INSURANCE AGREEMENT

PLEASE NOTE: THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF INSURANCE (THE LESSER OF $300,000 OR THE AMOUNT OF INSURANCE APPLIED FOR UNDER THE APPLICATION FOR INSURANCE HAVING THE SAME DATE AS THIS AGREEMENT), IF ALL THE CONDITIONS SET FORTH HEREIN ARE FULLY SATISFIED. THE COVERAGE PROVIDED IN THIS AGREEMENT IS IN EXCHANGE FOR THE DEPOSIT RECEIVED TOWARD THE INSURANCE APPLIED FOR AND NO AMOUNT SHALL BE CHARGED FOR THE COVERAGE PROVIDED HEREIN. NO REPRESENTATIVE OR AGENT HAS THE AUTHORITY TO WAIVE OR CHANGE THE TERMS OR CONDITIONS OF THIS AGREEMENT.

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3. Has any person proposed for insurance been diagnosed or treated for AIDS by a member of the medical profession, or had a positive test result confirming the presence of the AIDS virus (e.g. HIV, HTLV-III)? ☐ Yes ☐ No

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_____

_____

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There shall be no coverage under the insurance applied for until a policy is issued and accepted. If no policy is issued and/or accepted, the deposit shall be refunded to you.

CONDITIONS

Insurance on applicant, up to the Amount Limitation, will begin on the effective date, if:

1. There is no material misrepresentation in the application or answers to the Health Questions, and
2. All of the Health Questions are answered "No" with respect to that applicant; and
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I have read this Agreement and understand and agree to its terms. I understand this receipt provides no insurance unless all of its conditions are met and all required medical exams are completed. I declare that the answers to the Health Questions are true and complete to the best of my knowledge.

_____ _____

Date *Proposed Insured Signature*

By _____ _____

Representative *Owner (If other than Proposed Insured)*

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Representative's Note: Send original to Home Office with application and give copy to Proposed Insured (owner, if other than Proposed Insured).

SERFF Tracking #:	*AULD-128694673*	***State Tracking #:***	***Company Tracking #:*** *I-20833*

State:	*Arkansas*	***Filing Company:***	*Pioneer Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*Application for Life Insurance/I-20833*		

Supporting Document Schedules

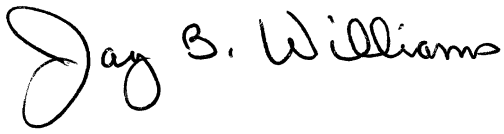
		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
READCERT-PML.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application		
Comments:	The application is attached to the form schedule.		

CERTIFICATE OF READABILITY

I, Jay B. Williams, Chief Compliance Officer of Pioneer Mutual Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS	READABILITY SCORE
I-20833	51.0



September 24, 2012

Jay B. Williams
Chief Compliance Officer